C+D
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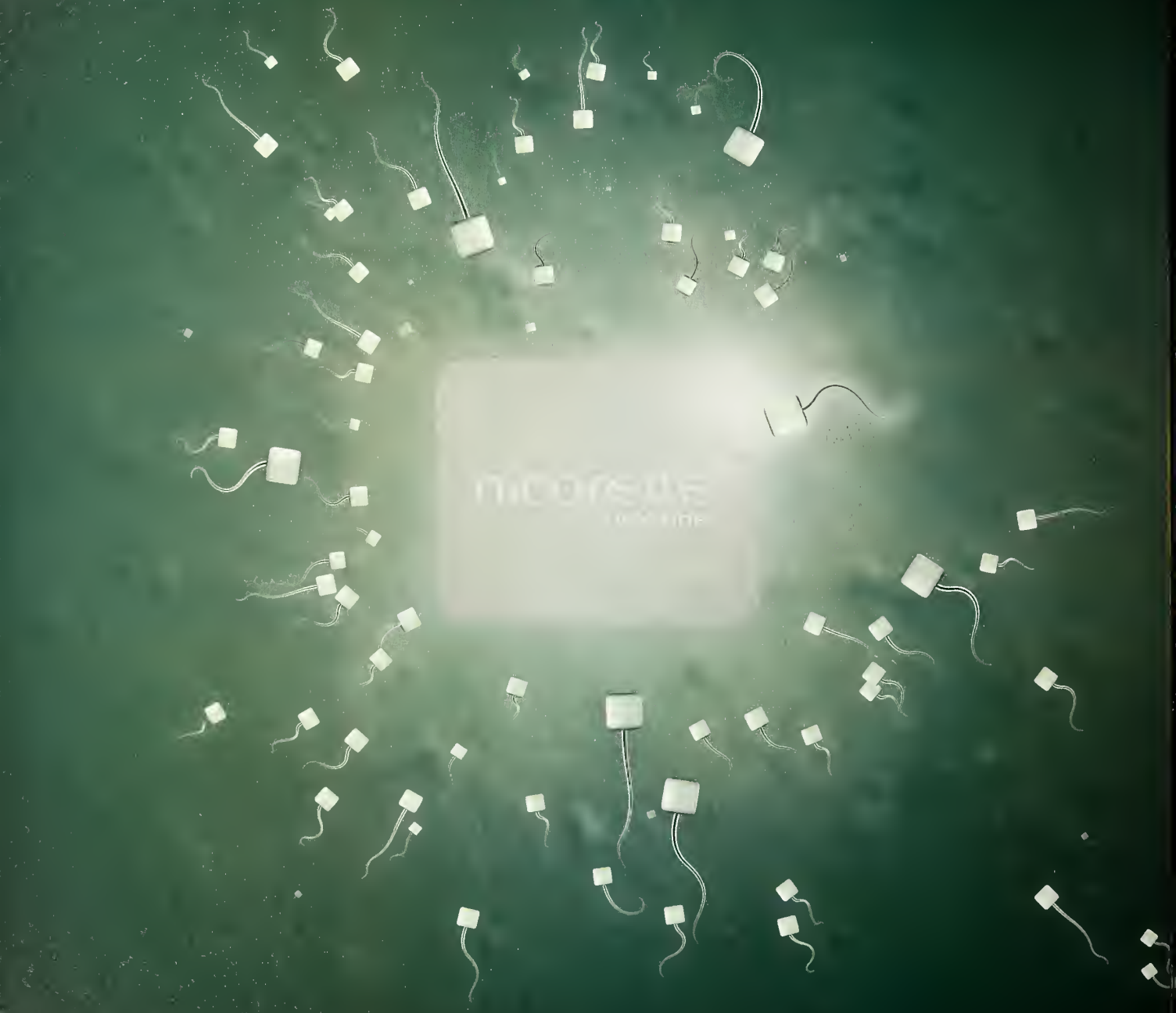
13 February 2010

when nicorette® patch meets nicorette® gum something remarkable happens

nicorette® combi™ patch + gum - a new conception in smoking cessation

51% more effective at helping smokers quit compared with 15mg patch alone at 12 weeks ($p<0.05$)[1]*



***34.2% quit on Combination NRT vs. 22.7% quit on 15mg patch at 12 weeks ($p<0.05$)**

Nicorette combi patch + gum Product Information

Presentation: Invisi 15mg 16 hour patch and Icy white 2mg gum. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation in smokers who smoke 10 or more cigarettes per day, experience breakthrough cravings, or who have previously failed on monotherapy. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin, hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. The gum should be chewed slowly for about 30 minutes when there is an urge to smoke. The patch and gum should be used together for the first 12 weeks. For the next 6-12 weeks, only the gum should be used. The gum should then be weaned for up to 9 months from the start of treatment. A maximum of 15 pieces of gum per day should be used. Those who use NRT beyond 9 months should consult a healthcare professional. **Adolescents (12 to 18 years):** As per adults except the patch and gum should be used together for 8 weeks only. For the next 4 weeks, only the gum should be used. Usage should be weaned over this period and discontinued after 12 weeks from start of treatment. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. *Patch only:* generalised dermatological disorders. Erythema may occur. If severe or persistent, discontinue treatment. *Gum only:* Denture wearers, GI disease. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Not recommended. **Side effects:** Headache, GI discomfort, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. *Patch only:* itching. *Gum only:* hiccups, sore mouth or throat, jaw-muscle ache. See SPC for further details. **RRP (ex vat):** Pack containing 7 Invisi 15mg Patches and 70 Icy white 2mg gum: (£22.56), **Legal category:** GSL. **PL number:** 15513/0359 **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **Date of preparation:** November 2009

Reference: 1. Kornitzer M et al. Prev Med 1995; 24: 41–47.

Date of preparation: January 2010 05402

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Generic substitution on trial

The C+D Senate gives its verdict See page 18

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GX-003-09. Date of preparation: December 2009

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Editor's comment

> 'WE'VE SEEN PHARMACISTS SHOWING REMARKABLE RESILIENCE AND INGENUITY AS THEY BATTLE FLOODS, EXPLOSIONS AND EVEN SNAKES'

If the analysts conducting the cost inquiry into England's contract funding had any doubts as to what they might uncover, the news that Lloydspharmacy is considering possible job cuts at its head office should serve as a stark reminder that pharmacy is not immune to the combined effects of the government's funding mechanisms and the wider recession.

If you flick through C+D's news pages from the past 18 months, it's clear that the sector is hurting, and Lloydspharmacy is not alone in this respect. There cannot be a pharmacy operator in the UK who hasn't had to make some uncomfortable decisions.

While PSNC's Sue Sharpe rightly cautions that the government has its own financial problems and will be closely examining the findings of the cost of service inquiry, there can be no doubt of the value and efficiency provided through the country's pharmacies. Especially given the ever increasing levels of regulatory burden, the rising number of new entrants, and the static global sum. It's remarkable just how much value the government gets from 90p.

The current financial market under which contractors operate provides little security for future years. The cost of service inquiry is likely to demonstrate this in cold hard facts and, if the Department of Health wants to turn the goodwill generated by its white paper into frontline services, it will need to find a fairer funding model.

Through hell and high water

Community pharmacy has a remarkable ability to deliver great services even under the most trying conditions.

The past month has seen pharmacists and their teams battling through treacherous weather conditions with the sole purpose of maintaining a pharmacy service for their local communities. We've also seen countless other pharmacists showing remarkable resilience and ingenuity as they battle floods, explosions and even snakes – all to ensure that they maintain a service.

This week, we salute another pharmacist. Despite finding that his pharmacy of 30 years had been destroyed by a fire, Chimanlal Patel of Bolton's Sykes Chemists has vowed to get his business back up and running from a temporary site just yards from the destroyed building.

Unless you've had to go through a similar situation, it's hard to imagine how you would deal with such a scenario. We can only marvel at the determination of some of our colleagues and wish them every success in getting back to normal.

Gary Paragpuri, Editor

News

Features

Multiples blast contract funding as Lloyds looks to make job cuts

UK's largest operators attack 'yo-yo' remuneration amid fresh redundancies threat

Jennifer Richardson
jennifer.richardson@ubm.com

The largest multiples have attacked England's pharmacy contract funding after Lloydspharmacy announced possible job cuts at its head office.

Lloydspharmacy said a "review of requirements" was driven by reduction in government funding for community pharmacy in England.

Deficiencies in the contract were also highlighted by the Co-operative Pharmacy and multiple member organisation the Company Chemists' Association (CCA), following Lloydspharmacy's announcement.

The Co-operative Pharmacy's managing director John Nuttall told C+D nothing had changed since it shed 26 branches in December 2008, which it also blamed on government funding cuts.

He said: "Over the last 12 months we have still seen the yo-yo of category M adjustments and the fundamentals haven't been addressed: the cost of service inquiry, what the new contract's going to look like, we're still allowing new entries to the market, diluting the funding."

And CCA chief executive Rob Darracott said other members were "concerned about the sustainability of the funding of the community pharmacy contract".

He added: "The cost of service inquiry is vitally important to demonstrate what we believe is a serious underfunding."

PSNC chief executive Sue Sharpe responded: "Financial constraints inevitably mean that a new government will look closely at the results of this year's cost of service inquiry, making it all the more important that we make a compelling case for further investment to further stimulate development of the role of community pharmacy."

A Lloydspharmacy spokesperson said the number of redundancies "was likely to be well below 100". The multiple had begun a 30-day consultation with affected staff and would make further announcements when this was complete, it said.

Co-op and Lloyds first warned the government over funding concerns nearly two years ago. A cost of service inquiry charged with delivering fairer funding is due to report in April.

Drying up: the fallout from the squeeze

JULY 08 – Day Lewis reveals head office job cuts
JULY 08 – Regional multiples Murrays Healthcare and McParland Pharmacies reveal widespread redundancies
DEC 08 – Co-op disposes of 26 pharmacies, blaming dwindling government funding
OCT 09 – Lloydspharmacy demands contract overhaul at C+D keynote conference
DEC 09 – Co-op boss cites £300m shortfall in contract funding
FEB 10 – Lloydspharmacy announces possible job cuts at Coventry head office

Unease over bid for 100 London polyclinics

Industry leaders have urged caution over plans to install over 100 new polyclinics in London by 2013.

Pharmacies are expected to feature in the polyclinics, NHS London revealed. But these could be new contracts or linked to existing networks, the organisation said.

But experts warned the clinics needed to be carefully planned, with input from LPCs, to avoid damaging the existing pharmacy network.

London PCTs have now developed plans for 102 polyclinics with "the vast majority" expected to be fully operational by the end of 2013. NHS London said pharmacies would have a "key role" in improving patients' health and wellbeing. "Pharmacies around the polyclinic hub will be equally important in providing patients with a supportive network of health services in the community," it added.

Alastair Buxton, head of NHS services at PSNC, warned: "PCTs need to look at the potential impact on the existing network of community pharmacies and agree on measures to deal with that."

C+D understands the NPA and some London LPCs have worked with NHS London in developing guidance for health trusts on the matter. **ZS**

What do you think of the polyclinic proposals?

haveyoursay@chemistanddruggist.co.uk

2010 C+D and PDA Union Salary Survey launches next week

C+D has once again joined forces with the PDA Union to uncover the truth about pay and conditions in UK community pharmacy.

The C+D and PDA Union Salary Survey 2010 will launch in the C+D email newsletter next week, asking questions on pay rises, benefits, working hours, workplace pressures and job security.

Last year's survey had almost 1,000 respondents. It found that almost half of employed pharmacists were unhappy with their salary, which on average was £38,400, and one in three pharmacists had been a victim of or witnessed a crime at work.

"The more people that respond to the survey, the more valuable it will be," said C+D editor Gary Paragpuri. "Please take part to make this a comprehensive resource on pay and conditions for community pharmacists and their staff."

To take part in the survey, visit **www.chemistanddruggist.co.uk/salarysurvey** from next Thursday. To receive an alert when the survey launches, sign up to the C+D newsletter at **www.chemistanddruggist.co.uk/register.**

The results will be published in C+D and on the website. **JR**

2009 results

£38,402 Average salary for employed pharmacist
£1,700 Average drop in annual locum earnings
79 The maximum number of hours worked by one pharmacy owner

C+D Senate puts generic substitution in the dock

Proposals create challenges for pharmacists, think-tank rules

Zoe Smeaton
zoe.smeaton@ubm.com

Plans for pharmacists to swap selected branded products for their generic versions have been dissected by industry leaders at the third C+D Senate.

Introducing generic substitution as proposed by the Department of Health (DH) could damage relations with the public, the think-tank warned. And the moves were not the best way for pharmacists to help cut NHS costs, the Senators said.

However some advantages, such as the opportunity it might present for pharmacists to engage with patients, were identified.

Having to think about swapping the drugs, which would be allowed unless GPs ticked a box to say they didn't want it to happen, could prove a distraction for pharmacists, the Senate warned.

C+D Senator Tricia Kennerley, group healthcare public affairs director for Alliance Boots, said: "I'm concerned that pharmacists are so busy and this is yet another thing that we're asking them to manage."

Other Senators said swapping drugs in this way could confuse patients, who might think pharmacists were doing it to save money for themselves.

But Jonathan Mason, a C+D Senator and the DH community pharmacy clinical director, urged pharmacists to express their views in the consultation the DH is currently holding on the plans. And he said of the proposals: "If you're having to explain to a patient why it is you're changing what the doctor prescribed, it is an opportunity to get in there and talk to the patient about their medicines and engage in dialogue."

Jonathan Mason (second left) urged sector to voice concerns via the consultation

Mr Mason was joined by key representatives from LPCs; multiples including Day Lewis, Rowlands and Superdrug; NHS Alliance and Actavis.

See our in-depth coverage of the C+D Senate on page 18

Minister calls shortages summit

Supply chain stakeholders have been called to a summit in March to tackle stock shortages with the pharmacy minister Mike O'Brien.

Details of the meeting emerged after C+D posed questions to the Department of Health following a national media report highlighting the shortages.

Mr O'Brien revealed that the meeting followed "months" of concern about the potential impact that a small number of medicines being sold abroad could have on patients' health.

"The secretary of state and I have called a summit in early March 2010 with all those organisations involved in the supply of medicines to better understand the issues involved and what might be done to address them," he said.

He added that the government believed a spirit of collaboration between stakeholders was the best way to further minimise risks to patients.

The comments followed questioning from C+D about a report on the Daily Mail website that highlighted the problems that stock shortages were causing for some patients.

The accounts echoed C+D's stock survey last year (C+D, August 22, p7) that found 89 per cent of pharmacists were "very concerned" patients could suffer as a result of shortages.

The Daily Mail report went on to blame factors including "wholesalers and some chemists" parallel exporting medicines, reduced distribution arrangements and drug quotas for the shortages.

The NPA, which was cited in the article, said it hoped Mr O'Brien would consider all relevant factors, "including changes to medicine distribution models" when tackling the problem. **ZS**

In brief

Wyeth switches to DTP

Wyeth's prescription medicines will be distributed via Pfizer's direct to pharmacy (DTP) distribution through Alliance Healthcare from April 12. The move follows the company's takeover by Pfizer.

Legal highs ban looms

So-called legal highs including mephedrone could be banned as early as next month, the home secretary Alan Johnson has said. **www.chemistanddruggist.co.uk**

Anthrax threat

A London heroin user has tested positive for anthrax, with experts suspecting the drug or its cutting agent is the cause, NHS London has warned. **www.chemistanddruggist.co.uk**

Repeats ordering system

A system allowing pharmacists to request repeat prescriptions online from lists held in GP surgeries has been launched nationwide. The MedsRequest service can be used with GP surgeries using IT systems provided by supplier EMIS. **www.chemistanddruggist.co.uk**

EPS template SOP

The NPA has produced a standard operating procedure (SOP) covering patient nomination. As part of the electronic prescription service, patients will be able to choose a pharmacy to have their repeat prescriptions sent to, and pharmacists can use the SOP when seeking this nomination.

Numark premises guide

Numark has produced an online resource to help members in Northern Ireland comply with revised premises standards published by PSNI. The resource includes template SOPs, free fascias and the group also offers a merchandising service.

APPG meeting

The all-party pharmacy group will meet on March 2 to discuss pharmacy priorities after the next election. The meeting will take place at 3pm at the Palace of Westminster. To confirm your place email **appg@luther.co.uk**

Dispensary talk

Do you feel comfortable asking customers about alcohol consumption?

"I'm happy to talk about the issue to customers I have already built up a rapport with.... but I wouldn't feel comfortable bringing up the issue without having had those sorts of initial discussions."
Nicola Matlock, Park Lane Pharmacy, Carshalton

"I would discuss alcohol consumption as part of a consultation and chat with a patient. But I wouldn't be as comfortable if this was an outright question with regards to a specific enhanced service."
Gordon Couper, Handbridge Pharmacy, Chester

Web verdict

Yes, I regularly ask patients 17%

No, but I ask when I suspect misuse 13%

No, only when necessary 70%

Armchair view: Pilots are underway on getting pharmacists to quiz patients over alcohol consumption. But it appears the profession needs some more Dutch courage to deliver these interventions en masse.
Next week's question:
What impact will polyclinics have on pharmacy? Vote at
www.chemistanddruggist.co.uk

Boots website under fire for homeopathy details

MHRA receives letter from anti-homeopathy campaigners

Chris Chapman
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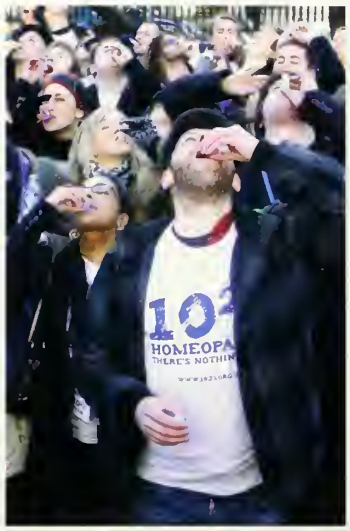
The UK drugs watchdog is studying a complaint about Boots' website from the pressure group responsible for homeopathy protests across the UK.

Boots is accused of breaching MHRA rules by promoting homeopathic products as cures for certain conditions. The multiple has denied the allegations and the MHRA has said no investigation has been launched. The material was featured on an educational website that did not support product sales, Boots stressed.

The complaint was made by the Merseyside Skeptics Society, which organised anti-homeopathy protests outside Boots stores earlier this month (C+D, February 6, p4).

A letter from the group to the MHRA said: "It appears to us that Boots is falling short of its aims to reflect integrity in the marketplace and is taking advantage of patients by selling products they admit to having no evidence for efficacy."



The Merseyside Skeptics Society is now targeting claims on the Boots website

Boots responded with a statement: "Bootslearningstore.com is our educational website for schools and does not support the sale of any specific products. Therefore the information on the site does not breach any advertising laws."

The products cited by the group were "correctly and legally labelled" and sold in accordance with MHRA regulations, the spokeswoman added.

The MHRA confirmed it had received the letter and was dealing with it, but stressed it was looking into a complaint and no investigation had been launched.

Since the complaint to the MHRA, a section of the Boots Learning Centre website outlining the use of homeopathy has been removed. However, the spokeswoman said the information had been taken down by Boots "as part of our regular review of the site" as it had been designed to support a course that ended in 2009.

Paul McCambridge/PressEye.com

Staff at a Boots store rallied to continue services after a car was driven through the pharmacy's windows in a ram raid. The vehicle, believed to be stolen, smashed through the front of the Boots branch in Markethill, Northern Ireland. The incident took place at 3.30am on January 27. The thieves escaped with a "large quantity" of aftershave and perfume, local police said. However, the branch remained open, with staff dispensing prescriptions from a side door until the wreckage was cleared, Boots confirmed. The store re-opened fully on January 29. Police are currently appealing for witnesses. CC

Wales eyes breakaway contract

The possibility of a new Welsh pharmacy contract based on quality as well as volume has been discussed by key industry leaders in the country.

A strategy day held by the delivery group charged with developing Welsh pharmacy services also identified a need to improve pharmacy relations with doctors and other health professionals.

Chris Martin, chair of the strategic delivery group, told C+D the strategy day had looked at how pharmacists could be part of a holistic care plan for patients. Incorporating quality measures into a new Welsh pharmacy contract was also on the agenda, although he warned such a contract was "still a little way off".

As C+D went to press, the National Assembly for Wales was expected to hold a debate on community pharmacy with the Opposition Welsh Conservative Group. See full coverage in next week's C+D. **ZS**

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In brief

Beclazone discontinued

Beclazone inhalers will be discontinued from March 31, manufacturer Teva has announced.
www.chemistanddruggist.co.uk

NCSO endorsements

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following items for February prescriptions: diltiazem 60mg MR tablets and pseudoephedrine 60mg tablets.

Age and fertility

Older women should still receive contraceptive advice, the Family Planning Association has said. The statement came as the charity launched a campaign highlighting unplanned pregnancies in women aged over 35.

CHD petition

More than 150,000 people have signed a petition calling for a new plan to tackle CHD. The petition, which was organised by the British Heart Foundation, calls for health equality impact assessments on all new services.

Reimbursement change

There will be a reduction of 2 per cent on reimbursement prices for Drug Tariff part XIA catheters, part IXB incontinence appliances and part IXC stoma appliances. The new prices launch on April 1.

Yellow Card problems

The MHRA has reported problems with receiving Yellow Cards through the post. Pharmacists who have had a Yellow Card returned or have not received an acknowledgment letter should resend the report by post or online.

Scottish praise

The Scottish public health minister has highlighted community pharmacy's role in increasing access to health services. Shona Robison told the Scottish Parliament that public health services provided through the pharmacy contract were "improving access to national health services".
www.chemistanddruggist.co.uk

Pharmacy owner left devastated by blaze

Stock delivery beside a heater thought to be the cause, says fire chief

Kathy Oxtoby
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A Bolton contractor is devastated after the pharmacy he has run for 30 years was destroyed by fire last week.

Chimanlal Patel said he was "absolutely shocked" by the blaze at Sykes Chemist in Daubhill. Fifteen firefighters battled for nearly an hour to control the fire, which is subject to an ongoing investigation to establish its cause.

Mr Patel told C+D: "I have no idea why this incident happened. We're all devastated. My manager and staff locked the shop at 6pm. Then a few hours later my alarm went off. By the time I got to the shop it was ablaze."

Emergency services were called after local residents saw smoke billowing from behind the pharmacy's security shutters.

Despite losing all stock to the flames, Mr Patel vowed to be open for business again as soon as possible.

He said: "I'm waiting for confirmation from Bolton PCT over a minor relocation. We've got a temporary site 150 yards down the road. I just want to get going out of the new site as soon as I can."

Fifteen firefighters battled for nearly an hour to gain control of the blaze

Meanwhile, experts were awaiting the results of an investigation to establish what caused the blaze.

Officials had originally believed the pharmacy was hit by an arson attack, local fire chief Karsten Boyle confirmed.

However, the blaze could also have been caused by a stock delivery left beside a heater, he told C+D. "As we speak that's the most probable cause," said the watch commander for Bolton Central Fire Station.

Mr Boyle added: "There might be a good chance that the stock was stored close to some plinth heaters. If the delivery included aerosols, that could have started the fire."

Mr Boyle said an accurate conclusion could not be drawn until police and fire investigators filed their report – due as C+D went to press this week.

Fines likely for data protection breaches

Pharmacies, along with other businesses, could be liable for fines of up to £500,000 if they are found to be seriously breaching the Data Protection Act, PSNC has warned.

The new penalties, which can be issued by the Information Commissioner's Office (ICO) from April 6, are designed to deter data security breaches.

Fines would only be issued in the case of a serious breach likely to cause substantial damage or distress, the ICO said. The office would also consider whether the breach had been deliberate and what steps had been taken by the pharmacy to prevent such incidents happening.

To prevent any penalties being incurred, the ICO suggested businesses should ensure they had carried out a risk assessment on the handling of personal data. For pharmacies, policies could include storing all sources of confidential patient information securely and encrypting laptops.

PSNC head of information services Lindsay McClure told C+D that pharmacists needed to be aware of the risks. **ZS**

Scottish approval for EHC drug

The five-day emergency hormonal contraceptive (EHC) pill has been approved for use across Scotland by an NHS advisory body.

The Scottish Medicines Consortium (SMC) accepted ulipristal acetate (EllaOne) on Monday for emergency contraception within 120 hours of unprotected sexual intercourse.

Currently, pharmacy-based EHC is only licensed for up to 72 hours.

The SMC move follows the results of a study last month that compared ulipristal with levonorgestrel. The Lancet study concluded ulipristal was an effective alternative for emergency contraception for up to five days. **CC**

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C+D AWARDS 2010

Puffapouch covers up inhalers

Pasante Healthcare is launching a range of asthma inhaler covers.

Puffapouch covers are designed to fit all 200 metered dosage asthma inhaler units and come in six colours and designs to appeal to all ages.

The pouch is washable and will help prevent the loss of the inhaler cap, making the inhaler units more hygienic. It comes with a neck strap and belt clip, allowing inhalers to be attached to key rings, clipped to a bag or worn around the neck.

Price: £4.99
Pasante Healthcare
Tel: 01903 753844

Fresh look for Vertese

Brunel Healthcare is relaunching its Vertese range of supplements with new packs that include Braille to aid partially sighted or blind customers.

The range comprises Omega Oils 3, 6 and 9, Glucosamine & Flaxseed Oil, Evening Primrose Oil and Flaxseed Oil. The relaunch will be backed by a £250,000 campaign.

Brunel Healthcare
Tel: 01283 228300

Chew over Calci-plus

Forum Health is launching a calcium supplement developed to be easy to take to aid long-term compliance conditions such as osteoporosis.

Calci-plus is a spray dried calcium carbonate, vitamin D3 and magnesium tablet. It has a sugar-free, natural lemon flavour and is formulated to be smooth and easily chewable.

The supplement provides 100 per cent of the recommended daily allowances of calcium, magnesium and vitamin D3. Two tablets provide 5mcg of vitamin D and 250mg of magnesium. The tablets also contain zinc, manganese and boron, which aid the absorption of calcium.

The launch is being supported with a promotional campaign that includes direct communication with GPs and nurses.

A pharmacy support programme includes point of sale materials and transfer order price promotions.

Price and Pip code: £4.99/30, 350-0766
Forum Health Products
Tel: 01737 781410

Market focus

- The £39 million calcium supplements category grew by over 7 per cent last year (TNS 2009).

C+D News Survey

As anti-homeopathy protesters target Boots, C+D asks for your views on the remedies causing the furore

Win an iPod Shuffle

Return the survey by February 24 and be entered into a draw to win an iPod Shuffle!

1. Do you think homeopathic remedies are beneficial as medical treatments?

a) Yes ☐
b) No ☐

2. What impact have recent protests surrounding homeopathy had on sales of the products at your pharmacy?

a) No change ☐
b) Negative: sales have decreased ☐
c) Positive: sales have increased ☐
d) We don't sell homeopathy ☐

3. Do you agree that pharmacies should sell homeopathic remedies?

a) Yes ☐
b) No ☐
Why?

_____

_____

4. Do you think the RPSGB guidance on homeopathy is clear?

a) Yes ☐
b) No ☐
Please give details

_____

_____

5. Do you think the NHS should pay for homeopathic remedies?

a) Yes ☐
b) No ☐

You can also enter the survey online at www.chemistanddruggist.co.uk

Your name: _____ **Job title:** _____

Pharmacy name and address: _____

_____ **Postcode:** _____

Email address: _____ **Daytime phone number:** _____

Post this completed page to: C+D, 8th Floor, Ludgate House, 245 Blackfriars Road, London SE1 9UY or fax it to 020 9721 8132.
All complete entries returned by February 24 will be put into a draw for the iPod Shuffle

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Xrayser

It's not easy being perfect

"If you were to spend the rest of your life with your peeing condition the way it is now, how would you feel about that?" An odd question for Mrs Xrayser to ask me, especially at work, but then she had got to the Flomax Relief training pack before me. I glanced down the 28-question checklist – decided that on the basis of "Frequency" and "Nocturia" alone, the next time I go drinking with a colleague we'll both need tamsulosin – and longed for the good old days when POM to P changes were much more simple.

To the pre-reg students registering now I'm sure 2010 will be the "good old days", but I sometimes wonder what became of my profession. We might not swear a Hippocratic Oath, but we have the Code of Ethics burnt into our brains, and we too seek to first do no harm. How much of our day do we spend turning down sales of medicines, because they are not appropriate – can you imagine a supermarket declining to sell a bag of crisps to an obese customer?

> CAN YOU IMAGINE A SUPERMARKET DECLINING TO SELL A BAG OF CRISPS TO AN OBESE CUSTOMER?

We pharmacists take seriously our responsibilities and obligation to the public. Patient safety and confidentiality are second nature, so no wonder that the survey a few years ago placed pharmacists as the second most trusted people after firemen. Yet my Fitness to Practice Declaration questions suggests the Society expects we're all one step away from an ASBO.

But, of course, we don't always get it right, as shown time and again by the Which? investigations. Hence the Flomax Relief training pack and, on the same day, the PSNC Information Governance workbook which, strangely, Mrs Xrayser left for me to open. That basically says the previously brief but succinct confidentiality briefing received by our staff is replaced by 20 pages of information governance training for them, and a whole lot of work for me.

It's not good enough that we get it right 99.9 per cent of the time and consequently are so trusted by the public, because when Something Goes Wrong, Something Must be Done, even though the post-Shipman changes wouldn't have stopped that psychopath from killing. Therefore we follow the protocol, we tick the box, and we ask the patient if he is "Mostly Satisfied" with his prostate. Get used to it – we work in the NHS, where if it's not written down, it hasn't happened...

But in many ways it is better not to do everything perfectly. The pharmacy inspector once told me that when investigating a complaint about a dispensing error, he has to be able to go back and say what is being done to stop it happening again, and a perfect pharmacy that has just made a simple human error is unacceptable. The prospect of such an Orwellian future is enough to drive anyone to drink – just remember to take the tamsulosin with you!

Nick Barber

When evidence doesn't match reality

Twice the bridesmaid. In the English Board Elections, in both the open and academic sections, I got more votes than anyone else – anyone who was not elected, that is. In each case I was beaten by candidates who are against remote supervision.

My own view is that I am for pharmacy and for patients being safe and receiving a great service. I will assess remote supervision against those principles when I see the fine detail. However, as an academic who studies how policy is made, I have to say the case for the pharmacist needing to be present is looking weak to any external group who looks at the literature (which is how policy makers work).

Studies that have checked dispensed items show that in community pharmacy, with a pharmacist present, there is still an error in the content or label of one in 30 items dispensed to patients, and in one in 10 items dispensed to care homes. Even though most errors were clinically insignificant, as around 1.6 million items are dispensed per day, it suggests community pharmacists are missing or refusing to correct over 50,000 errors a day. Hardly supporting evidence for pharmacists needing to be in the dispensing process to ensure accuracy. In contrast, in a hospital pharmacy where technicians dispense and check, the dispensing error rate appears to be well under 1 per cent.

So how are we at pharmaceutical care? The evidence shows another grim picture with the recently published £1 million MRC RESPECT study showing, as have other large RCTs, that community pharmacists had no impact. To the external observer it looks like we can't dispense and are clinically ineffectual.

I don't think the evidence matches reality. I know some remarkable community pharmacists with excellent practice. The dean of a London medical school recently told me that his Tesco's pharmacy acts as the local A&E – people queue to consult the pharmacist at times when the GP surgeries are closed – and in the dean's view the advice the pharmacist gives is excellent. So the question is, how do we get better evidence about what pharmacists do?

As a trustee of PTECO (a charity that supports research into pharmacy), I will encourage fellow trustees to commission work in this area – reviewing existing evidence and commissioning new research. Meanwhile, I will continue to research what community pharmacists do and evaluate any technology anyone asks me to evaluate, as I have done for the past 20 years.

The new evidence we generate may or may not support remote supervision, however it will allow us to make judgements and negotiate with others from common ground.

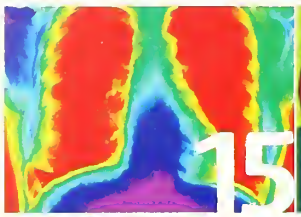
Professor Nick Barber, Centre for Medication Safety and Service Quality, The School of Pharmacy, University of London

> TO THE OBSERVER IT LOOKS LIKE WE CAN'T DISPENSE AND ARE CLINICALLY INEFFECTUAL

Features

C+D Senate

Generic substitution was the topic of the day as the 10 industry leaders met to deliver their verdict on the DH's plans



Update: Respiratory Health Month

Learn to tell the difference between asthma and COPD

Practical Approach

A persistent, barking cough is an unusual case for Update Pharmacy

How to get out out of a lease

Your options when negotiating a favourable solution

C+D Awards

Scotland's Martin Green on what it takes to become Business Leader of the Year

Jobs

Meet Asif Sharif, the pharmacist running Lloyds' online pharmacy

Update

Your weekly CPD revision guide

Module 1513

Is it asthma or COPD?

The signs, symptoms and diagnostic tests

Doreen Cochrane MRPharmS

Asthma and chronic obstructive pulmonary disease (COPD) are associated with considerable morbidity and mortality and place a heavy burden on healthcare. These groups of patients make frequent GP visits and emergency hospital admissions.

Patients with these conditions are managed mainly in primary care. It has been estimated that the average community pharmacy dispenses medicines for 452 patients with asthma and 78 patients with COPD. The oportunities for community pharmacy to be integrated into local care pathways for these patients have been widely discussed and the National Clinical Strategy on COPD, due early in 2010, may reveal how this will be achieved.

Asthma aetiology

Asthma is a chronic inflammatory condition that produces narrowing of the airways, usually in response to an irritant, that is reversible either spontaneously or using treatment. A list of asthma triggers is available in the full version of this article at www.chemistand druggist.co.uk/update. As a result of airway inflammation and structural changes, the airways of asthma patients become hyper-responsive and give rise to one or more of the four most common symptoms – cough, breathlessness, wheeze and chest tightness.

The exact mechanism of the inflammatory response to asthma is not yet fully understood; a complex interaction seems to occur between patient and environmental factors. Genetics seem to play an important part in its development.

In response to an irritant the middle layer of the airway (the submucosa) becomes swollen, the mucus glands produce more secretions giving rise to cough, and the smooth muscle of the airway contracts following release of inflammatory mediators. These changes provide the basis for both the diagnosis and treatment of asthma.

For all but the most mild forms of the disease, regular anti-inflammatory treatment with inhaled corticosteroids is used to prevent airway inflammation, while short- or long-acting bronchodilators are used to relax the airway smooth muscle and prevent constriction on exposure to stimuli that cause bronchoconstriction.

As asthma becomes persistent, scar tissue may build up in the submucosa, leading to irreversible airflow obstruction. Patients with asthma who develop permanent obstruction are considered to have COPD, and the two conditions may co-exist.

COPD aetiology

COPD is an umbrella term for two related diseases – chronic bronchitis and emphysema. It is characterised by airflow obstruction that is usually progressive, not fully reversible and does not change markedly from day to day over a period of months. In the early stages, the majority of patients display few symptoms. Later, patients experience exertional breathlessness, chronic cough, winter 'bronchitis' or possibly wheeze. The major symptom of COPD is breathlessness. Cigarette smoke causes the lungs to produce additional mucus and is responsible for more than 95 per cent of cases of COPD.

Occupational exposure to dust may also contribute to COPD. The only known genetic cause is deficiency of alpha-1 antitrypsin (an enzyme preventing other enzymes in the body from destroying tissues, mainly the lung and liver), which contributes to 2 per cent of cases of severe COPD.

COPD is the main condition in the differential diagnosis of asthma in adults and distinguishing between the two is not always straightforward. Patients who request medicines for a chronic cough or who ask for help with smoking cessation may benefit from further advice. The WWHAM protocol can be used to establish the pattern of

Table 1. Differences between asthma and COPD

	COPD	Asthma
Smoker or ex-smoker	Almost always	Possibly
Symptoms under age 35	Rare	Common
Chronic productive cough	Common	Uncommon
Chest tightness	Persistent and progressive	Variable
Atopic disorders	No link	Common
Family history	Rare	Common
Significant diurnal variation in symptoms	Uncommon	Common

Respiratory Health Month

February's Update articles on respiratory disease continues with articles on the diagnosis and treatment of asthma and COPD. The articles will appear in print and online at www.chemistanddruggist.co.uk/update

60-second summary

Do you know the differences between asthma and COPD?

Asthma is a chronic inflammatory condition that produces reversible narrowing of the airways, usually in response to an irritant. The main symptoms, which can vary during the day, are cough, breathlessness, wheeze and chest tightness. It can occur in childhood and is often linked with atopy. COPD mostly affects smokers and is characterised by airflow obstruction that is usually progressive and not fully reversible. It is rare under 35. The main symptom is breathlessness.

What confirms the diagnosis?

Spirometry to determine the degree of airways obstruction and its reversibility. This article, which can be used as part of your CPD, explains the measurements.

This article (Module 1513) can help in the following CPD competencies: G1a, G1c, G1d, G1s, C1e.
See http://tinyurl.com/68ox7b

Respiratory calculations

Calculating the percentage improvement in FEV_1:
The percentage improvement in FEV_1 is calculated as follows:

$$\%\ \text{improvement in } FEV_1 = \left(\frac{FEV_1\ (\text{post administration}) - FEV_1(\text{baseline})}{FEV_1\ (\text{baseline})}\right) \times 100$$

The BTS/SIGN diagnostic criteria for asthma using spirometry are:
- FEV_1 greater or equal to 15 per cent (or 400ml) increase after a short acting beta-2 agonist (eg salbutamol 400mcg by pMDI + spacer)
- FEV_1 greater than 15 per cent (or 400ml) increase after trial of steroid tablets
- FEV_1 greater than 15 per cent decrease after six minutes of exercise (running).

COPD is unlikely if FEV_1 and the percentage improvement in FEV_1 return to normal with treatment.

Peak expiratory flow:
Where asthma is suspected, the patient can monitor peak flow by recording readings at least twice a day over a period of two weeks. Percentage peak flow variability may be calculated from the highest and lowest peak expiratory flow rate (PEFR) achieved during one day:

$$\%\ \text{Peak flow variability} = \left(\frac{\text{Best PEFR} - \text{lowest PEFR}}{\text{Best PEFR}}\right) \times 100$$

When more than 20 per cent diurnal variation is seen on three or more days in a week for two weeks, a diagnosis of asthma is highly likely.

Table 2. Objective diagnostic measurements and COPD

Severity	Measurements
Mild	FEV_1/FVC<70% FEV_1 50-80%
Moderate	FEV_1/FVC<70% FEV_1 30-49%
Severe	FEV_1/FVC<70% FEV_1<30

Diagnostic criteria as stipulated by Nice. Other classifications are available, such as GOLD (Global Initiative for COPD).

the customer's symptoms. Both groups will benefit from stopping smoking as current smokers usually have poorly controlled asthma and smoking further reduces lung function of patients with COPD. Patients with asthma who are obese benefit from weight loss and from signposting to weight management programmes. Breathing tests, especially spirometry, with or without a chest X-ray, form the main objective measures used in diagnosis and management of asthma and COPD.

Disease prevalence

The prevalence of childhood asthma has peaked at a high level in many developed countries. In the UK, one child in 10 has asthma in the UK and 5.8 per cent of patients registered with general practices are on asthma registers. In 2007-08 there were 38,500 emergency bed-days in England for children and young people under 19 years with a primary diagnosis of asthma.

There is a six-fold difference between PCTs in England with the highest and lowest rates of child admissions and a four-fold difference for adult admissions. Emergency and A&E admissions are highest in areas of socio-economic deprivation, and many of the exacerbations that led to these visits could have been prevented.

The estimated prevalence of COPD, based on analysis of recent data from GP disease registers in the UK, is 1.5 per cent (almost 800,000 patients). But the actual prevalence is complicated by under-diagnosis; one study estimated a true prevalence of three million with COPD in the UK. Rates appear to be increasing in women but have reached a plateau in men. Populations in inner cities and in areas of former heavy industry, including mining, are most affected. Many of these areas have high levels of socio-economic deprivation.

Screening offers potential for earlier diagnosis of COPD, allowing improvements to patient outcomes through evidence-based interventions aimed at reducing the rate of loss of lung function, with benefits in terms of symptom progression and survival. To make best use of healthcare resources, screening programmes need to be targeted at high-risk groups (smokers over 35 years and those with symptoms suggestive of COPD). Raising awareness of lung health is a key public health issue.

Making a diagnosis

In children, diagnosis is based on recognising symptoms that increase or decrease the probability of asthma, based on the child's history, physical examination and careful consideration of alternative diagnoses. A personal history of atopy or a family history of atopy or asthma are strongly associated with an eventual asthma diagnosis.

In children many wheezy episodes are triggered by viral infections and treatment with inhaled steroids is not always effective.

In adults, the decision to diagnose asthma is based on the recognition of a characteristic pattern of symptoms and signs that increase or decrease the probability. Spirometry is used to see if airway constriction is reversible. Heart failure and COPD are the main diseases that need to be considered in the differential diagnosis for this age group.

For both adults and children where the diagnosis is of high or intermediate probability, the clinician may try treatment with bronchodilators and review the patient's response.

There is no simple diagnostic test for COPD. The clinician relies on clinical judgement based on the patient's history including smoking, physical examination and confirmation of non-reversible airflow obstruction using spirometry. Patients under 40 years of age should also be tested for alpha-1 antitrypsin deficiency.

Spirometry

Spirometry is used to measure the movement of air into and out of the lungs. It also measures the rate of air flow. Results are compared against predicted values for the patient's age, height, gender and ethnic origin.

The diagnostic measurements required include:
- Forced expiratory volume in one second, representing the volume of air expired quickly in the first second after maximal inspiration (FEV_1).
- Forced vital capacity, representing the volume of air that can be forced from the lungs after maximal inspiration (FVC).

Nice defines airflow obstruction as a reduced FEV_1 (less than 80 per cent of predicted values) and FEV_1/FVC ratio (less than70 per cent of predicted values). The results of objective diagnostic measurements and severity are compared in table 2.

In patients with suspected asthma, reversibility testing is performed by measuring the patient's breathing parameters at baseline and after administration of a beta-2 agonist. See Respiratory calculations (above left).

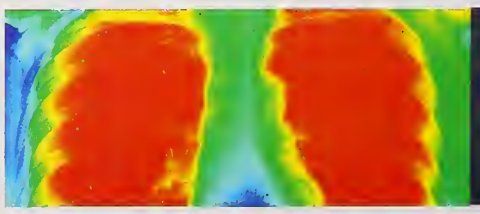
Pharmacy involvement

There are examples of community pharmacist involvement in providing services for patients with asthma or COPD, and pharmacists could contribute much more in terms of case finding and patient education about these conditions. A framework published by the Welsh Pharmacy Board (see http://tinyurl.com/ycrkjmt) recognises the value of prevention in this clinical area, and the need for an integrated multidisciplinary approach across all tiers of healthcare services that would give pharmacists a bigger role in care of patients with asthma and COPD.

Doreen Cochrane MRPharmS is an independent pharmacist prescriber in respiratory conditions.

A further reading list is in the full version of Update at www.chemistanddruggist.co.uk/update.

Update subscribers: download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.



NEXT WEEK
Respiratory Health Month continues as Update discusses drug treatment for asthma

Is it asthma or COPD?

Reflect

What are the triggers for asthma? Which symptoms are common in asthma but not COPD? How is spirometry used to diagnose asthma or COPD?

Plan

This article describes the main differences between asthma and COPD including symptoms and causes. It also includes information about the use of spirometry in the diagnosis of both conditions.

Act

- Read more about asthma and its epidemiology, presentation and diagnosis on the Patient UK website at http://tinyurl.com/yzqrg2c.
- More information about COPD and its diagnosis can be found on the Patient UK website at http://tinyurl.com/yzsuab6 and http://tinyurl.com/y8brheo.
- Find out more about spirometry and how it aids diagnosis of asthma and COPD, from the Patient UK website at http://tinyurl.com/ygbbwo7.
- Think how you could explain COPD to a patient; the British Thoracic Society has a useful leaflet at http://tinyurl.com/lxp8h4.

Evaluate

Are you now familiar with the differences between asthma and COPD? Could you advise patients about them? Are you confident in your knowledge of spirometry and its diagnostic uses?

5 minute test
What have you learned?

Test yourself in three easy steps:

Step 1

Register for Update 2010 and receive a unique PIN number

Step 2

Access the 5 Minute Test questions on the C+D website at **www.chemistanddruggist.co.uk/mycpd**

Step 3

Use your PIN to complete the assessment online. Your test score will be recorded. If you successfully complete the 5 Minute Test online, you will be able to download a CPD log sheet that helps you complete your CPD entry at uptodate.org.uk

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Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach — Test yourself in this everyday pharmacy scenario

A persistent, barking cough

A woman, accompanied by a tired looking teenage girl, comes into the Update Pharmacy. The woman asks to speak to the pharmacist, and David Spencer comes to see them in the consultation area.

"I want something really effective that will stop Sophia's cough," the woman says.

"Tell me a bit more about it," David replies. "What sort of cough is it, how did it start and how long has Sophia had it?"

"It started with a cold, then it developed into a dry, barking cough, very persistent – there, you can hear it for yourself," says the woman as Sophia obliges with an example. "She's had it for two weeks now. It's keeping her awake at night, and she says that her teacher at school has complained because her coughing bouts are disturbing classes."

"Have you done anything about it before now?" David asks.

"Of course! I bought some cough mixture, but that didn't work, so I took her to the doctor a week ago. She said it would probably clear up in a few more days, but as you can see it hasn't," the woman says, as Sophia coughs again.

"I've come across something like this once before," David says. "If you agree, I'm going to contact your GP and send you back to her."

The woman and Sophia agree. A week later they return with a prescription for erythromycin.

"Thank you so much," the mother says. "Sophia's still got the cough but my mind's easy now."

Questions

1. What were the contents of David's note to the GP, and what was the basis for his comments?
2. What did the GP do, and why did she prescribe erythromycin?
3. What is the prognosis for Sophia's cough?

Answers

1. David suspected that Sophia might have whooping cough. It is often overlooked in older children and adults because the classic inspiratory 'whoop' is often attenuated and because people have been immunised against it. However, it should be considered as a possible diagnosis in any adolescent or adult with an acute cough of more than two weeks' duration, even if they have been fully immunised. About 20 per cent of individuals with cough lasting more than two weeks have evidence of recent whooping cough and it recurs throughout adult life – it has been estimated that people have up to three episodes in a lifetime, despite immunisation.

2. She took a blood sample and sent it for analysis for the presence of a raised titre of antipertussis toxin IgG, which is diagnostic. (Culture of a nasal swab for the presence of Bordatella pertussis, the causative organism, is less sensitive.) Treatment with a seven-day course of erythromycin within 21 days of onset of symptoms may not affect outcome for the patient, but it reduces the period of infectivity and may prevent transmission to household members.

3. In all age groups, irrespective of immunisation status, the cough lasts an average of three months.

This article can help with these CPD competencies: G1a, G1c, G1d, G2o, C1a, C1f.
See http://tinyurl.com/68ox7b

Do you have an idea for a Practical Approach scenario or would you like to write one? Email us at: **haveyoursay@chemistanddruggist.co.uk**

C+D Senate

The new community pharmacy think-tank

THE C+D SENATE
IN ASSOCIATION WITH actavis

TOPIC: **Generic substitution**

Will government plans for generic substitution really work? C+D's Senators weigh up the evidence and deliver their verdict. **Zoe Smeaton** reports

The Senators (left to right)

Max Gosney
News editor, Chemist+Druggist
Peter Cattee
Managing director, PCT Healthcare
Ash Soni
Contractor, Copes Pharmacy, London
Martin Crisp
Superintendent pharmacist, Superdrug
Jonathan Mason
National clinical director for pharmacy, Department of Health
John D'Arcy
Commercial director, Rowlands Pharmacy
Andrew McClean
UK marketing manager, Actavis
Gary Paragpuri
Editor, Chemist+Druggist
Jay Patel
Area manager, Day Lewis
Tricia Kennerley
Group healthcare public affairs director, Alliance Boots
Georgina Craig (not in picture)
Pharmaceutical services commissioning network lead, NHS Alliance

Generic substitution will be challenging, could lead to friction with the public, and is not the most effective way for pharmacists to help the NHS save money, the C+D Senate believes.

The conclusions came as 10 industry leaders met in London to form a position on the topic, and they spell bad news for Department of Health (DH) plans.

The Department wants pharmacists to be allowed to swap selected branded products for their generic versions, unless GPs have ticked a box to say they don't want it to happen. It might sound straightforward enough on paper, but many Senators are not convinced.

The main issue for Jay Patel, an area manager at Day Lewis, is the added distraction that generic substitution would bring. "It's the mental fog – it's just one more thing to have to worry about," he says. And Tricia Kennerley, group healthcare public affairs director for Alliance Boots, agrees: "I'm concerned that pharmacists are so busy and this is yet another thing that we're asking them to manage. We're going to have to think very carefully regarding the training and support we give."

How big an issue is this?

The DH thinks the initial impact on pharmacy in volume terms will be low, as only around 40 drugs would be eligible for substitution. It could affect only five to 10 prescriptions per day per pharmacy, according to Jonathan Mason, the DH national clinical director for pharmacy.

The other Senators agree this may be the case, but are concerned the workload for those few prescriptions could be onerous depending on how patients react.

John D'Arcy, commercial director at Rowlands, says: "We're going to get different attitudes. It's the same as with Kellogg's cornflakes: somebody would say, 'Are they Kellogg's? Because if they're not I don't want them,' whereas someone else will say the generic equivalent suits them." And Mr Patel agrees: "If Mrs Jones's tablets are different, she could be thinking, 'They aren't the same, they aren't going to work and why didn't he give me what the doctor wrote down?'."

Substitutions could even reduce compliance,

warns Ash Soni, a community pharmacist in London. "We do have patients who will turn around and say 'I won't take that because I always have the one that's brown rather than orange and I prefer that,' or 'I do not take yellow tablets'," he explains.

From Mr D'Arcy there are also concerns about how the move could affect the public's perception of pharmacy. "However you put the message across, are patients going to think, 'He's doing this because he makes more money,' rather than seeing it as part of a government cost containment strategy?"

Georgina Craig, pharmaceutical services commissioning network lead at NHS Alliance, says to move forward we need to understand these issues better. "We're stabbing in the dark a bit about how patients are going to react to this. I think it is the responsibility of the DH to

Generic substitution at a glance

Pros

- Speeds the shift from branded medicine to generic use as drugs go off patent
- Presents an opportunity to engage with patients about their medicines
- GP prescribing of generics could increase further as they know patients will get generics anyway

Cons

- Introduces yet another potential distraction for pharmacists
- Patients may feel that pharmacists are profiting by switching medicines
- Generic substitution is small fry compared to the benefits of increasing patient compliance

The Senate warned the financial implications of generic substitution for pharmacy must be considered

understand what some of the issues might be and to support pharmacists by giving them access to that information so they can anticipate in advance what some of the issues are likely to be."

In response, Mr Mason stresses that pharmacists have dealt with most of the issues already, such as when a branded medicine comes off patent and patients have to switch to using generics. "When something comes off patent pharmacists already have to explain to the patient that the drug has come off patent and is in different packaging even though it's the same drug." He says with the proliferation of parallel imports and generics, patients are already used to medicines coming in different packaging.

But even if this is the case, the Senators warned pharmacists needed to be allowed to opt out of substitutions in some cases. "If I feel the patient is in such a position that I do not feel it is ►►

> "It's the same as with cornflakes: somebody would say, 'Are they Kellogg's? Because if they're not, I don't want them'"
>
> JOHN D'ARCY, COMMERCIAL DIRECTOR, ROWLANDS PHARMACY

> "If Mrs Jones's tablets are different, she could be thinking 'they aren't the same, they aren't going to work'"
>
> JAY PATEL, AREA MANAGER, DAY LEWIS

appropriate to substitute and it is the right thing to give them the brand, will I be penalised? That then takes away my opportunity to make a good clinical decision on behalf of the patient," says Mr Soni. Liability is also a concern for Ms Kennerley, who asks if pharmacists would be liable for changes they make that lead to adverse reactions. And others are concerned about the possibility of friction with GPs. As Mr Soni says: "It will be interesting to see what GPs think; I suspect they will come out against this because of the perception that it's weakening their power base."

Will it affect funding?

The C+D senators were undecided on how the switches might affect pharmacy income, but agreed the matter needed serious consideration.

Ms Kennerley said: "If we're switching more products into generics, we've got more going into supply chain margins so it will have an impact on funding overall and we need to think that through."

And Mr Soni questioned whether the move would have an impact on branded generics. "It might diminish this market which has been used by PCTs as a lever to push prices down. That may help to relieve some of the pressure on some pharmacies who are theoretically not getting their share of the shared pot of generic margins we're supposed to have."

Focusing on the positives

Whatever the problems with generic substitution, though, the DH is convinced it will bring benefits. Mr Mason explains that there will be a longer term benefit as new drugs can be added to the list when they go off patent, speeding up the shift from branded medicines to generics. "There is a big time lag at the moment between [a medicine going off patent] and getting a big volume of medicines through generically to make the big savings," he says.

And it could also bring opportunities for pharmacy. Mr Mason suggests: "If you're having to explain to the patient why it is that you're changing what the doctor has prescribed, it is an opportunity to talk to the patient about their medicines and engage in dialogue."

Martin Crisp, Superdrug's superintendent pharmacist, agrees: "Pharmacists are seasoned at doing this and it could be that generic substitution might create an opportunity for an MUR."

Most of the Senators are unconvinced, though, and feel other moves could bring more benefit. Ms Craig asks: "If it's going to cost more time for pharmacy to do this, and if this additional time is going to bring a small return on investment, is there something better that pharmacists could be doing with that time?" Improving compliance is seen as a higher priority, as Mr Soni explains: "Compliance is a much bigger issue. Compared with the amount of money we're talking about there, this is like a drop in the ocean."

Another option is to introduce substitution further up the chain, with GP surgeries taking responsibility for prescribing generically. "For each GP surgery there are around three pharmacies, so for one practice manager to take control makes more sense," Mr Patel says.

Mr Mason backs a role for GPs, but insists generic substitution could create opportunities for engagement with the two sectors. Maybe it's an opportunity to go to GPs and say, 'Well if you don't prescribe generically it's going to be

> "It's time that we had a broader discussion about the cost of medicines in society involving patients as well"
>
> PETER CATTEE, MANAGING DIRECTOR PCT HEALTHCARE

Hands on debate: Senators discussed the practical implications of generic substitution

switched anyway. Do it now so you won't have to go through the hassle of explaining to patients when they come back and say the pharmacist has switched it and they have told me x, y and z'."

Whether this will work or not remains to be seen, but the Senators are certainly united on one front: the need for a full discussion on the matter. They are keen to get patients involved in that, as Peter Cattee, managing director of PCT Healthcare, says: "It's time that we had a broader discussion about the cost of medicines in society involving patients as well." But above all, they want the profession to have its say and respond to the DH consultation to ensure that if generic substitution is introduced, it works.

Next week in C+D: The Senate dissects the thorny issue of commissioning, and questions whether the RPSGB can deliver a new leadership body

Peter Cattee:

"Nothing I have heard has reassured me with regard to the considerable number of problems that will be associated with the practical aspects of this."

Jonathan Mason:

"It is a consultation. We want people's views and contrary to what people may believe the DH does listen and we will look at the responses."

Tricia Kennerley:

"I don't see anyone being a real advocate of this. I think it's fraught with a lot of challenges that I'm not sure we're going to get the benefit from... the cost of the switch could possibly be not dissimilar to the [value] of the saving."

Martin Crisp:

"The reality is that government has got to save money and I would rather see money saved here and hold on to service investment and commissioning than look at a cut in potential new income streams. I think it's a necessary evil in some respects."

Ash Soni:

"I'm not convinced that this is a major change in terms of what it will do apart from create more aggravation than it will save in money."

The Senate ruling

- **Generic substitution is not the most effective way for pharmacy to help reduce NHS costs**
- **Patients should be involved in making decisions about drug spends**
- **If generic substitution goes ahead, pharmacists need the ability to opt out where appropriate**
- **The financial implications for pharmacy must be considered**
- **Pharmacists must respond carefully to the consultation**

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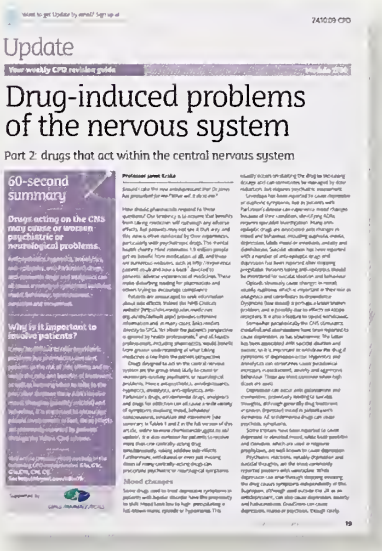
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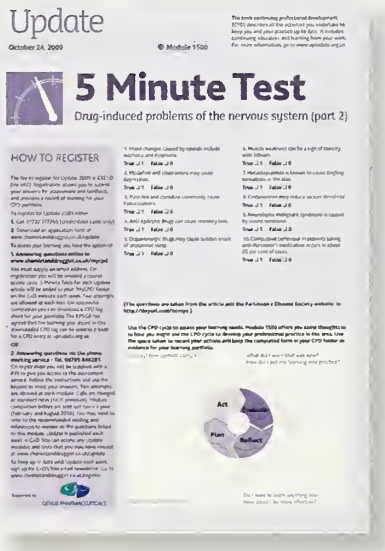
Drug-induced problems of the nervous system

Part 2: drugs that act within the central nervous system

60-second summary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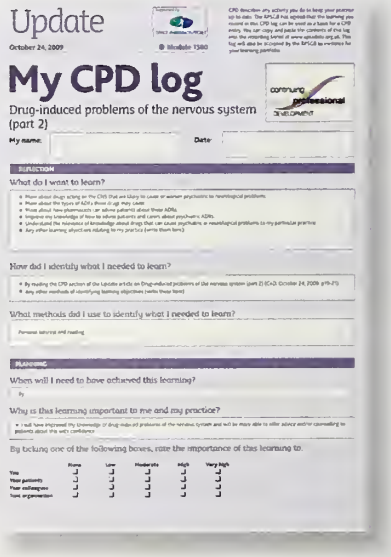
5 Minute Test

Drug-induced problems of the nervous system (part 2)

HOW TO REGISTER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My CPD log

Drug-induced problems of the nervous system (part 2)

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How to get out of a lease

After retailers including Lloydspharmacy attacked landlords' 'archaic' rental terms, property law expert **Philippa Aldrich** continues her look at your rights and responsibilities

Part 1 of this series was published in the January 23 issue of C+D

The cost of occupying a commercial building is usually the main overhead for a business. If an existing commercial lease is proving too expensive, how can a tenant get out or change the terms?

A lease is a legal document into which you are probably tied for a number of years. But there are options available for businesses which need to dispose of their lease or renegotiate its terms so, if you consider your options early, you may be able to reach a favourable solution.

Assigning or subletting

First, you should check if you have the right to assign or sublet the whole or part of the lease with the landlord's consent. By assigning the lease, you would be released from your obligations in relation to the property, but you may be required to comply with pre-conditions. Subletting, although not disposing of the lease, may at least allow you to recover some costs.

Break options

Many commercial leases allow you to break it at a specified time or on specified events; this can be used as an exit route for struggling businesses. It is, however, essential that break options are exercised strictly in accordance with their terms. It is common for break options to require at least six months' notice, therefore early consideration of exercising this right is essential. If the date by which notice must be given passes, the right to break is lost and you must bear the cost of the lease until the next break opportunity, or look to other, less certain, ways of releasing your obligations.

Options to break can also be used as a tool for renegotiation. The threat of losing you through the exercise of a break clause and being faced with an empty building may encourage landlords to consider terms more favourable to you. If your problems are cash-flow related, the landlord may be willing to reduce the rent or alter the payment terms, such as allowing monthly rather than quarterly rents. Alternatively, landlords may consider sharing the risk of market turbulence and renegotiate rent to a percentage of your turnover. They may even be willing to agree payment plans for rent in arrears to ease the pressure during tough times.

Surrender of a lease

It may be possible for you to negotiate a surrender of your lease with the landlord's consent. If the landlord agrees to surrender, you will be released from any future liability under the lease. It is important to note, however, that any breaches that occurred before the surrender remain enforceable by the landlord. You should therefore ensure that you seek a release from all breaches.

But if the business goes bust can you simply hand back the keys? If you give up possession of your premises and hand back your keys to the landlord you may be able to prove that the landlord has agreed this as surrender of the lease. While surrender requires the agreement of both parties, if the landlord acts in a way to suggest agreement, such as re-letting the premises, you will be released from your future liabilities under the lease. But landlords are unlikely to accept the keys as surrender, in which case your continuing liability as an insolvent tenant under the lease will depend on the nature of the insolvency.

Company voluntary agreements

If you are hoping to rescue your business, you may enter into a company voluntary arrangement (CVA), a contractual arrangement with creditors supervised by a licensed insolvency practitioner. This way, you may avoid liquidation through the use of cost-effective arrangements with creditors, including landlords, regarding the payment of rents and debts. However, a CVA must be approved by 75 per cent in value of creditors and the procedure for implementation is cumbersome.

Liquidation

If your company goes into liquidation, the landlord can seek arrears of rent up to the date of commencement of liquidation. Claims for rent due after commencement can only be made with court approval, but it is likely in any event that the liquidator will use his powers to 'disclaim' the lease. A disclaimer will have the effect of extinguishing your rights, interests or liabilities as tenant.

Administration

Administrations have become very popular since the Enterprise Act 2002 introduced a simplified out-of-court procedure. Administration allows for an attempt to be made at putting a company back on its feet. At commencement of administration, a statutory moratorium is placed on all proceedings against the company during the period of administration. Also, the landlord will be prevented from bringing any action to recover rent or the property without first obtaining the consent of the administrator or the court.

Philippa Aldrich is a former partner in the Real Estate Group, Shadbolt & Co

Take home points

- Consider your options early.
- Check if you have the right to assign or sublet.
- Break clauses are good negotiation tools with advance planning.
- If you negotiate a surrender of your lease, ensure there is a break from all clauses.
- Your liability as an insolvent tenant will depend on the nature of insolvency, and may be dealt with by a company voluntary agreement, liquidation or administration.

C+D AWARDS 2010

In association with NPA National Pharmacy Association

Business champ

Meet Martin Green, the lateral thinking business leader, who delivered a landmark funding deal for Scottish pharmacy. **Max Gosney** reports

Every leader has a watershed moment where their reputation is either won or lost. Julius Caesar crossed the Rubicon, Martin Luther King had a dream and for Scottish contractors Martin Green secured a landmark funding deal.

"My biggest challenge was this year's financial package," says the chair of Scotland's contract negotiator, Community Pharmacy Scotland (CPS). "With the financial climate, we could see their [Scottish Government Health Directorate's] hands were tied. They recommended that we work on a two-year deal because there was a strong likelihood 2010-11 was going to be even tougher."

The two sides appeared incompatible. Health officials wanted to control costs to offset a future squeeze on NHS finances. Meanwhile, Mr Green and CPS craved a pay rise that gave pharmacists stability and confidence to invest in new services. At first it appeared a discussion destined to lead to disappointed pharmacy representatives.

Ministers agreed to increase the pharmacy funding pot by 1.9 per cent in 2009-10 and 1.6 per cent the year after. The rise looked paltry compared to a booming 7 per cent under the previous settlement. "The uplift in the global sum was not particularly thrilling," Mr Green reflects. But look behind the headline figure and you find a hidden treasure. Mr Green explains: "We recognised it was not easy for them to find more money, but there was the possibility to reinvest some of the existing money from pharmacy purchase profits."

Mr Green had hit upon a third way – one where the government got its savings, and contractors still picked up a funding rise. He explains: "What we said was: there will be money generated by the industry through savings on generic drugs, but we ask you to plough that money back in."

Health bosses saw the advantages. They agreed to extend a £50 million cap on pharmacy purchase profits by £14m. On top of the rise they agreed to split any excess margins above the £64m with contractors through the Efficient Purchasing and Prescribing Programme, and reward continued savings in future contracts. Everyone appeared to be a winner. Pharmacists netted extra cash to fund business and service development while the NHS benefited from a cheaper drugs bill.

Getting the government to lift the £50m profit cap also held great significance, says Mr Green. "This was the first time the government had acknowledged it was unacceptable to keep purchase profits at a fixed figure." Margins had slowly been eroded by the arrival of new drugs on the market since 2005, Mr Green explains. But until this year's funding deal this had gone unrecognised. Now contractors can celebrate a potential 28 per cent uplift in generic buying profits, with the promise of more. Mr Green concludes: "The potential for future years is huge. If we had developed a model like this when we first introduced purchase profits then pharmacy would be a very different place."

> "Mr Green had hit upon a third way – government got its savings and contractors still picked up a funding rise"

Name
Martin Green

Company
Community Pharmacy Scotland (CPS), Edinburgh

Award won
C+D Pharmacy Business Leader of the Year 2009

Award entry
Helped put community pharmacy at the vanguard of Scottish healthcare through successful contract negotiations

Best part of winning
Getting the acclaim from peers. Mr Green was flooded with congratulatory texts after picking up his prize

How Martin Green won the C+D Business Leader of the Year Award 2009

Background: Martin Green has been a pharmacist for over 20 years. He owns a chain of nine pharmacies in Glasgow and has been chair of CPS since 2006.

Highlights:

- secured funding for three national public health services through local pharmacies
- negotiated a 28 per cent boost in purchase profits for 2009-10 funding
- launched an award-winning wall chart system that allows contractors to maximise funding opportunities
- delivered closer communications with local contractors through the modernisation of CPS.

Leadership style: Mr Green has an open and inclusive style. He is happy to make key decisions but will seek counsel when he feels it's necessary. He says: "I know the minimum of what I'd like to achieve. I will then ask my board if they think I have drawn the line in the right place." Mr Green is quick to praise his CPS colleagues and credits them heavily for his own awards success. He also advocates complete transparency with members. "I used to hate it when I was a contractor and you were told, 'You're better off not knowing that,' in response to a question."

Negotiating style: Mr Green takes a collaborative approach to negotiations. He tries to appreciate what the other party wants rather than issuing a take it or leave it stance. But he will only budge so far. He says: "I have my breaking point. I know what I would like to achieve and what I wouldn't settle for."

Pearl of wisdom: "I have always been passionate about pharmacy. If other people have that approach then they will achieve."

If I had been given the chance to make an awards speech: "It would have been to emphasise my delight to have won, not just on a personal level, but for the CPS team."

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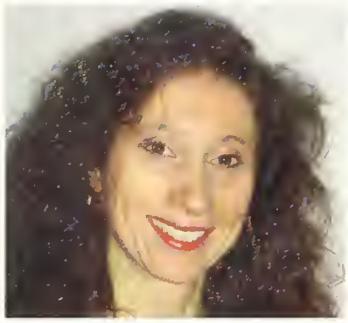
Career ladder

... at the RPSGB



The RPSGB has appointed former university lecturer Nina Barnett (above) as a professional support consultant. She will take up a one-year secondment in the Society's professional development and support team as "an important part" of its transformation into the future professional leadership body. Ms Barnett has 22 years' experience in pharmacy practice, including lecturing and tutoring at King's College London, and Brighton. She is an independent prescriber and became England's first consultant pharmacist for older people in 2007.

... at AAH

AAH Pharmaceuticals has appointed Nigel Draper as commercial director. He will be responsible for the wholesaler's procurement and pricing of generics, PIs and OTCs. Mr Draper joined AAH at the start of the year following roles in senior supply chain management and procurement at companies including Whitbread and Barclays.

... at the ABPI

The Association of the British Pharmaceutical Industry (ABPI) has appointed Amanda Stuart (above) as its head of government affairs. Formerly associate director of public relations agency Insight Public Affairs, Ms Stuart will be responsible for communicating the ABPI's messages to politicians and civil servants in Westminster and Europe.

My pharmacy life

Lloydspharmacy's Asif Sharif reveals to **Jennifer Richardson** his career path from pre-reg to online pharmacist

I'm the chief pharmacist at Lloydspharmacy online, where we aim to provide all the services we possibly can that you'd get in a high street pharmacy. We have a full dispensing contract, offering NHS dispensing and a prescription collection service through Royal Mail. And we sell all the things you'd find in a normal pharmacy – your GSL and pharmacy medicines.

I have to look at all requests and decide whether we should sell things – it's safe and ethical. Customers always get contact from us when they place an order, giving them my contact details, and in probably one in four sales the customer will get an email asking for further information. I'm the only pharmacist on duty at any time – when I'm not here, we have locum cover.

We also offer an online doctor service, where people can log on from the comfort of their own homes and have a consultation with a doctor. The doctor will securely email us a prescription, we send the medicines out to the patient, and they should get them the next day.

I did my pre-reg with Lloydspharmacy and then took a position with The Co-operative Pharmacy as pharmacy manager, as I was keen to go straight in to management. I wanted to see everything I possibly could in community pharmacy, so I then decided to locum – and over the next two years I worked in a variety of settings. It worked, because I saw so many different strategies.

I decided to take this role at Lloydspharmacy online because it was unusual and challenging, and would let me see pharmacy across the UK. It was totally unique from anything I'd seen before, but it was still a community pharmacy – just using the online medium – so I leapt at the chance and have not looked back since. It's been 16 months now.

Asif Sharif: a role with many highlights

It was unusual at first because you can't make eye contact with the customer or judge their body language on the phone, but I quickly learned to adapt to that, choosing my style of questioning so I get everything I need – it's like having a virtual customer in front of you.

There's no typical day here – but we do have our bread and butter services, everything's very organised and we have strict deadlines to meet. We have a rapidly growing NHS trade. Our hours are 9am to 6pm, very similar to a high street pharmacy – though we're very lucky here because everybody gets a lunch break. People use the internet 24 hours a day, so to meet customers' needs we'll look to expand our hours, particularly in the evening – if demand is there we'll grow to meet it.

The more weird and wonderful activities that pop up are those from abroad or uncommon medicines – the unusual requests are probably my favourite parts of the job. People come to us on the website, when they wouldn't walk into a pharmacy and ask for these things, because they feel more comfortable doing so. The dull but necessary tasks are checking orders and stock counts – the things that need to be done but aren't particularly fun.

There have been many highlights in this role. One of the things I'm most proud of here is that we work with head office to look at new services before we launch them and give feedback to help iron out any issues. One of the things we have done recently is with the swine flu pandemic – we wanted to dispense Tamiflu to patients in advance of need, which required a completely new computer programme and a completely new way of dispensing. In the initial wave we dispensed 1,000 doses in a couple of days – a huge success.

Also the launch of Alli as a pharmacy medicine was very successful after we worked with head office to work out what I needed as a pharmacist to feel safe and comfortable with the sale. Being consulted on things, influencing decisions at head office and seeing things implemented is very rewarding.

I have no plans to go back into a high street pharmacy at the moment because I'm enjoying what I'm doing so much, but I wouldn't rule it out.

I am motivated by achieving things that haven't been done before. When people ask me what I do, at things like branch meetings, they're taken aback and very interested, and I often end up with a crowd of pharmacists around me asking questions – it's very enjoyable talking about my role.

My ambitions are to develop and grow as much as I can as a pharmacist, and build this business further. Hopefully, I will achieve things that are recognised by my peers across the field, but for now I'm very happy with my role.

Career tip of the week

"Avoid unpleasant surprises. When you know things are going to go wrong, let the customer know as soon as possible, do not just hope that things will get better... they usually get even worse. Customers approached in good time will usually be receptive to a sensible negotiation about managing the problem."
From Brilliant Manager, by Nic Peeling
www.chemistanddruggist.co.uk/booksforjobhunters

RECRUITMENT

Feeling good about management

Running a pharmacy store is a challenge that appeals to pharmacists with business acumen and management aspirations and there is no-one that offers more opportunities than Boots UK. **Tharndeep Sembhi** – or **'Tuz'** to his friends – sees it as a chance to learn about the business and expand his career horizons. Tuz manages one of our 'your local Boots pharmacy' stores. We caught up with him, eighteen months into his first management role, to find out how he's getting on, and whether he still sees himself as a pharmacist.

"Absolutely. No question. It's what I qualified for and it's still the main part of my job – helping customers face-to-face. As a Store Manager I love having such a variety of other things to do as well, because I really am running a business here. Whilst still getting to know my customers I've also been learning all about the people management and commercial aspects of pharmacy. Whenever things get really busy I know that help from my Area Manager or Regional Pharmacy Manager is only a phone call way. At Boots, that kind of support is always there. Just ask Jina, my colleague who features in our current pharmacy recruitment campaign. Only the other day she was asking my advice about becoming a Store Manager and I was only too happy to take time out for a chat.

"From my experience, I told her that the Stepping Stones training programme for potential Store Managers is a fantastic option for anyone who really wants to move on and up. When you stop and think how many Boots stores there are in the UK, you realise just how much opportunity there is to keep progressing in all kinds of directions. Being a Pharmacy Store Manager has opened up lots more avenues for me to explore, both in terms of my career and my personal development."

If you think you might be interested in following the same path as Tuz, please visit **www.boots.jobs/pharmacy**

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EXPRESSIONS OF INTEREST

NHS Havering

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The contract will be procured via an LPS (Local Pharmaceutical Services) contract and would involve integration and partnership working with the on-site GP Led Practice, on-site minor injuries unit and potentially consultant led and other services.

It is anticipated that the contract will commence in June 2010.

The Provider will be required to provide essential, advanced and potentially some locally commissioned enhanced services. At ITT stage Bidders may be asked to suggest potential enhanced services that they are willing to provide, including proposals of how these may be provided for discussion.

Further information about the above scheme and the procurement process can be found in the Memorandum of Information (MOI) which is available on the NHS Havering web-site:

http://www.havering.nhs.uk/ngen_public/default.asp?id=204

Interested parties wishing to participate in the NHS Havering Procurement must submit an EOI, in the required format as detailed in Annex B of the MOI, by email to **comm.projectspa@havering.nhs.uk**

EOIs must be received no later than 12 noon on Friday 26 February 2010. NHS Havering will issue an email acknowledgement confirming receipt of the EOI within 48 hours of receipt.

If no such acknowledgement is received then you should contact **Ann Marie Salter on 01708 465203** to check that your EOI has been received.

EOIs submitted after this deadline will not be considered. A Pre Qualification Questionnaire (PQQ) will be issued to all organisations submitting an EOI in the required format and by the due time and date.

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Postscript...

Online with C+D

Talking points

"There is no reward for honesty in this profession. I am not surprised most pharmacists I have met always put their own security first before the interests of the patient when faced with tricky situations in community practice – we have an axe hanging over our heads all the time!"
Shelton Magunje on the morphine error case. Posted on C+D online.

The top stories last week

1. Pharmacist must wait on morphine error verdict
2. Anti-homeopathy protesters vow to step up campaign after rally
3. Pfizer kicks off generics range with six drugs

To post a comment, simply register at www.chemistanddruggist.co.uk/register

Study buddies

It's now two thirds of the way through the pre-reg year for most of this year's crop of budding pharmacists. And, with thoughts up and down the country drifting towards the pre-reg exam looming on the horizon, Postscript thought it would lend a hand.

C+D's website is chock full of useful resources for pharmacists-to-be, with everything from pharmacy-based scenarios to a massive resource of questions and answers to help prepare candidates for the open and closed book sessions. There are even hints and tips on how to tackle calculations, and a blog from newly qualified pharmacist Ravi Patel.

For help and top tips on passing the pre-reg exam, head to www.chemistanddruggist.co.uk/generationrx and get some practice.

C+D Reader of the week

Meet pharmacy assistant Sally Ingram, of Lloydspharmacy in Coventry, and find out why Barack Obama would be her ideal dinner guest

Will you join the new professional leadership body? No, I'm a pharmacy assistant!

What's the best thing about your day? I really enjoy working with my colleagues. We all get on really well, and it's a nice environment to work in.

What's your pet hate? Rude customers. We do get a few. And impatient customers, too.

What object could you not live without? My phone – especially in this shop. I've got an internal phoneline now, because they're all fed up answering for me. I spend most of my day working on the phone.

What did you have for lunch? A jacket potato. We work on a really nice high street, so there are lots of bistros that we can go to.

What superpower would you want? Telepathy, it would make my job easier! I could know what people want before they come in. And I could avoid them if they're not nice.

Who would be your ideal dinner party guest? Barack Obama, the President of the United States. I find him really interesting – I don't find Gordon Brown interesting. I would want to find out how he got to where he is from where he came from. The other option would be a sportsman. I love football and rugby, so maybe the England manager, Fabio Capello – and an interpreter!

What should we ask the next interviewee? What's your ultimate goal in life?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

Web Hunter

You've probably heard of it. I know some of you already use it. But what am I, and everybody else, talking about? Why, Twitter of course.

I'm going to assume no one has used it and work up from there. Twitter, according to itself, is "a real-time information network powered by people all around the world that lets you share and discover what's happening now".

You type 140 characters about something, maybe include a link, press return and, Bob's your uncle, all your followers will receive it. In the case of C+D (or @chemistdruggist), 385 people will.

But why is this useful? Well firstly it allows us as an information source for pharmacists to get news out to our readers instantly – or faster than email anyway. Secondly it allows you to interact with C+D in a very personal way: you send a message to us via Twitter and we endeavour to answer you directly. You can also interact with our writers: @CandDChris, @CandDJennifer, @CandDGav, @CandDZoe, and @TheWebhunter.

The third reason to use Twitter is to search. Type 'generic substitution' into Twitter search and, as fast as Google, you can find everyone on Twitter who is talking about it. Why not just Google it? Well it comes down to this: Google will bring you back web pages of articles about the subject, some of which will be very good and informative. With Twitter you get something different.

Twitter gives you people's direct experience and opinion of a subject, unedited and immediate. There are also a lot of clever people creating bespoke ways of searching Twitter. Google 'health tweeder' and see what you get.

I hope from reading this you give Twitter a try. And if I haven't convinced you, then think about this – Stephen Fry manages to interact with 1.3 million followers. What better demonstration could there be of the power of tweets?

Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com

C+D's week in tweets

@CandDChris: One advantage of London location: proximity to Borough market. Where else can you get an ostrich burger for lunch?

@CandDGav: Updating my Who's Who entry. No, REALLY!

@CandDJennifer: Just spoke to Co-operative Pharmacy MD John Nuttall...

@CandDZoe: Told off by a press officer because apparently "without delay" is not quite the same as "at the earliest opportunity". Not convinced.

Springboard

Springboard Pre-registration Training Programme 2010-11

Springboard is an exciting pre-registration training programme, offered in partnership by **C+D** and **Medway School of Pharmacy**.
Springboard covers all aspects of the community pharmacy experience and assists the trainee in making a smooth transition from student to professional.

The programme consists of eight in-house study days covering:

- Responding to symptoms
- Law and Ethics
- Controlled Drug regulations
- Medicines use reviews
- Drug Tariff
- Pharmaceutical calculations
- Dressings and wound management
- Monitored dose units
- Smoking cessation
- Drug misuse
- Management
- Communication skills
- First aid
- The NHS and how it works
- Influencing your PCT
- Auditing your services
- Clinical cases using the BNF
- Practice exam questions

The programme enables the student to meet the appropriate competences in the RPSGB pre-registration student handbook, and offers support to pre-reg tutors via a tutor training day and throughout the year. Students are allocated a nominated personal tutor in addition to their pre-reg tutor in the workplace.

This programme is unique in that the students have the opportunity to be accredited to provide medicines use reviews. Additionally students are able to accumulate credits by completing distance learning courses included in the programme that can be put towards a postgraduate qualification.

All eight student study days and the tutor day will be held at a central London location.

For more information on the **Springboard** course, complete the slip below and return to:
Kinna McConochie, 8th Floor, Ludgate House, 245 Blackfriars Road, London SE1 9UY.
Alternatively, call Kinna on 0207 921 8413 or email kinna.mcconochie@ubm.com

❒ **YES**, please send me more information on the **Springboard** pre-registration training programme

Name

Address

Postcode Email

C+D
in association with

Medway School of Pharmacy
University of Kent
the University of Greenwich

Help men take control of their annoying pee problems

The launch of Flomax Relief brings you the first and only effective,[1] non-prescription drug treatment for BPH in men aged 45-75.[2] BPH is a progressive enlargement of the prostate, which causes annoying pee problems in 1 in 4 men aged over 40.[3]

To find out more, visit **ww.flomaxrelief.co.uk/hcp**

Boehringer Ingelheim

Flomax Relief® MR – Product Information. Presentation: Flomax Relief MR containing 0.4mg of tamsulosin hydrochloride in a modified release capsule. **Indication:** Treatment of functional symptoms of benign prostatic hyperplasia (BPH). **Dosage:** For men aged 45-75 years. For oral use. One capsule daily. **Contraindications:** Hypersensitivity to any ingredients of the product; a history of orthostatic hypotension; severe hepatic insufficiency. **Warnings and Precautions:** Men taking an antihypertensive alpha$_1$-adrenoceptor blocker should consult a doctor before taking Flomax Relief. In individual cases a fall in blood pressure can occur. Do not give to a man who experiences postural hypotension. Consult a doctor before taking Flomax Relief if a man has heart, renal, or liver disease, uncontrolled diabetes, urinary incontinence, or has had prostate surgery. Do not supply Flomax Relief to a man whose symptoms are of less than 3 months' duration. Do not supply to a man who reports dysuria, haematuria, or cloudy urine, in the previous 3 months, or who has a fever that might be related to urinary tract infection. Do not initiate treatment in a man planning cataract surgery, or who has recently experienced blurred or cloudy vision not examined by a doctor or optician. If urinary symptoms have not improved within 14 days of starting treatment the patient should be referred to a doctor. Medical review is required for diagnosis of BPH: Patients must see their doctor within 6 weeks of starting treatment for assessment of their symptoms and confirmation to continue taking Flomax Relief long-term from their pharmacist. Every 12 months, patients should be advised to consult a doctor. **Adverse Effects:** *Common:* dizziness *Uncommon:* headache, palpitations, postural hypotension, rhinitis, constipation, diarrhoea, nausea, vomiting, rash, pruritus, urticaria, abnormal ejaculation, asthenia. *Rare:* syncope angioedema. *Very rare:* priapism. Drowsiness, blurred vision, dry mouth or oedema can occur IFIS has occurred in some patients during cataract surgery. **RRP (ex VAT):** 14 capsules £7.65, 28 capsules £14.46 **Legal Category:** P **Product Licence Number:** PL 00015/0280. **Date of revision:** December 2009. **Further information available from:** Boehringer Ingelheim Limited, Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire RG12 8YS. **References** 1. Narayan P et al. Journal of Urology 1998;160:1701-1706. 2. Flomax Relief MR Summary of Product Characteristics. 3. Simpson RJ et al. British Journal of General Practice 1994;44:499-502 **Date of preparation:** December 2009/FMX0133

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).